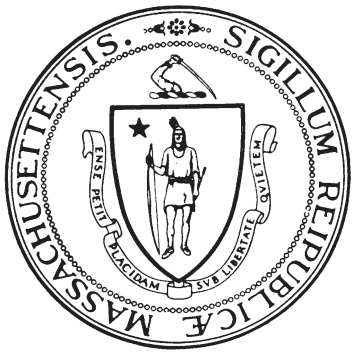
Massachusetts Division of Health Care Finance and Policy

Uncompensated Care Pool PFY 2002 Utilization Report

December 6, 2002

Linda Ruthardt, Commissioner

Prepared for the Joint Committee on Ways and Means of the Massachusetts 182nd General Court



Jane Swift, Governor
Commonwealth of Massachusetts

Robert P. Gittens, Secretary
Executive Office of Health and Human Services

Massachusetts Division of Health Care Finance and Policy

Uncompensated Care Pool
PFY 2002 Utilization Report

December 6, 2002

Linda Ruthardt, Commissioner

Jane Swift, Governor
Commonwealth of Massachusetts

Robert P. Gittens, Secretary
Executive Office of Health and Human Services

Table of Contents

Contributing Staff: Susan Kennedy Dugan, Richard Fitzmaurice, Beth Gies, Katharine London, Susan Madden, Rachel Safford, Uthara Swaminathan, Gordon Wong

Statutory Basis for the Report

Chapter 177 of the Acts of 2001, line 4100-0060 included the following provision to which this report responds.

> "... provided further, that said division shall submit to the house and senate committees on ways and means not later than December 6, 2002 a report detailing utilization of the uncompensated care pool; provided further, that said report shall include:
>
> (1) the number of persons in the Commonwealth whose medical expenses were billed to said pool in fiscal year 2002;
> (2) the total dollar amount billed to said pool in fiscal year 2002;
> (3) the demographics of the population using said pool, and;
> (4) the types of services paid for out of said pool funds in fiscal year 2002;
>
> provided further, that the division shall include in said report an analysis on hospitals' responsiveness to enrolling eligible individuals into the MassHealth program, so-called, upon the date of service rather than charging said individuals to the uncompensated care pool;
> provided further, that said division shall include in said report possible disincentives the state could provide to hospitals to discourage such behavior; ..."

Report of the Division of Health Care Finance and Policy
The DHCFP took special steps to ensure that it could identify an unduplicated number of Pool users for the purpose of responding to the requirements of the statute.

The DHCFP began collecting eligibility data for individuals who use the Uncompensated Care Pool to pay for health care services on October 1, 2000 and clinical service data for these individuals on March 1, 2001. The care received by an individual across multiple providers is not linked, in part because many Pool users do not have social security numbers. In addition, techniques were used to help compensate for other hindrances such as typographical variances in the spelling of names and multiple home addresses. The DHCFP employed a relational database and sophisticated algorithms to match patient identities across providers. Thus, the resulting estimate of the unduplicated number of Pool users is statistically valid. The DHCFP can now report on the actual population that uses the Pool with relative certainty, whereas in the past, the Commonwealth could only make inferences using data from other populations.

1) Total number persons whose medical expenses were billed to the pool in FY02.

   In the Uncompensated Care Pool's FY2002,[1] medical expenses for an estimated 346,000 individuals[2] were billed to the Uncompensated Care Pool.[3] [4] Charges for payment for services for 171,000 of these individuals were submitted to the Pool by hospitals as regular free care, of which pool was the primary payer for 140,000.[5] Charges for another 119,000 individuals were submitted by hospitals as emergency bad debt, while bills for 56,000 individuals were submitted by freestanding community health centers.

   Two or more claims were billed to the Pool for an estimated 217,000 individuals whose services were billed to the Pool in FY02, while only one claim for services was billed for the remaining 129,000 individuals.

[1] The Uncompensated Care Pool's Fiscal Year, abbreviated as PFY, runs from October 1 through September 30.
[2] These individuals include Massachusetts residents, as well as out-of-state residents who received urgent and emergency services charged to the Uncompensated Care Pool.
[3] Figures reported in this section are the result of a method that is designed to produce unduplicated counts from the data submitted by providers. In order to avoid double counting among types of claims (e.g., emergency bad debt, inpatient, et al.) users were assigned to the category of the most recent claim submitted for services used by that patient.
[4] Caution should be taken when comparing this UCP user count with a count of the number of uninsured individuals in the Commonwealth, based on survey results. The Commonwealth's survey, like most surveys of the uninsured, asked whether an individual was uninsured on a particular date, rather than whether the individual had been uninsured at any point during a one year period.
[5] The Pool would be the secondary payer when another public or private insurer is the principal or primary payer; the balance for which the low-income patient is responsible is then be charged to the Pool.

2) The total dollar amount billed to the pool in FY02.

In FY2002, a total $881,736,745 in free care charges was billed to the pool by hospitals and community health centers (CHCs). A total $859,267,669 was billed by hospitals and $22,469,076 was billed by CHCs in FY2002.

The DHCFP reduces the charges billed to the Pool to allowable free care costs. The Pool pays these allowable free care costs, to the extent that funding is available. Figure 1 below highlights the sources and projected uses of the FY2002 pool funds. For comparisons across fiscal years, refer to Appendix B. For an explanation of the difficulties in projecting Pool expenses, see Appendix C.

Sources & Projected Uses of Pool Funds (in millions), FY 2002		
Sources of Funds		
	Hospital Assessment	$170
	Surcharge on Payments to Hospitals	$100
	State Appropriation	$30
	Intergovernmental Funds Transfer	$70
	Transfer from Medical Security Trust Fund	$90
	Transfer from the Tobacco Settlement Fund	$12
	Total Funds Available	**$472**
PROJECTED Uses of Funds		
Payments		
	Boston Medical Center Free Care Costs	$155
	Cambridge Health Alliance Free Care Costs	$85
	Other Hospitals Free Care Costs	$199
	Community Health Centers Free Care Costs	$23
	Demonstration Projects	$5
	Transfer to Children's and Seniors' Fund	$34
	Audit Adjustments	($4)
Reserves		
	Doubtful Accounts - Hospitals	$1
	Doubtful Accounts - Surcharge Payers	$0
	Data Collection	$2
	Total Uses of Funds	**$498**
(Shortfall)/Surplus		**($26)**

Figure 1.

3) The demographics of the pool population in FY02.[6]

The eligibility and clinical services databases identify common characteristics of the population that relies on the pool for health care coverage. As the data in the following pages indicates, the majority of pool users are single, childless adults, ages 19-64, with very low-incomes.

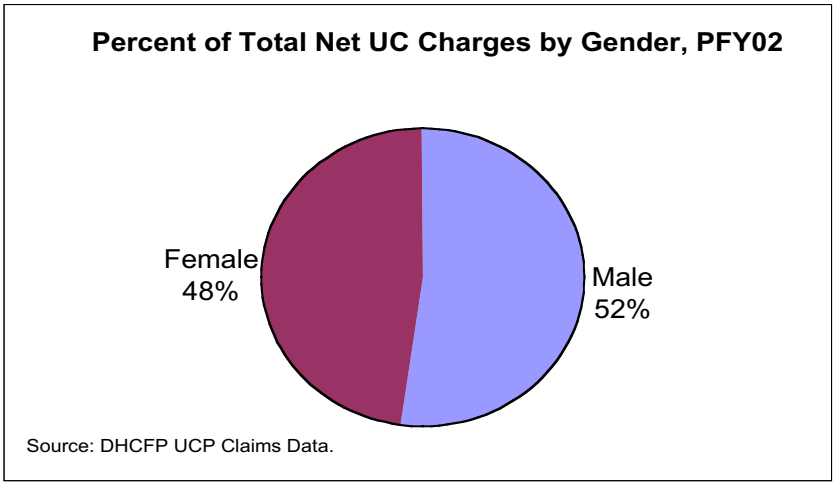


Figure 2. Males comprise a slightly larger percentage of uncompensated care charges[7] than females.

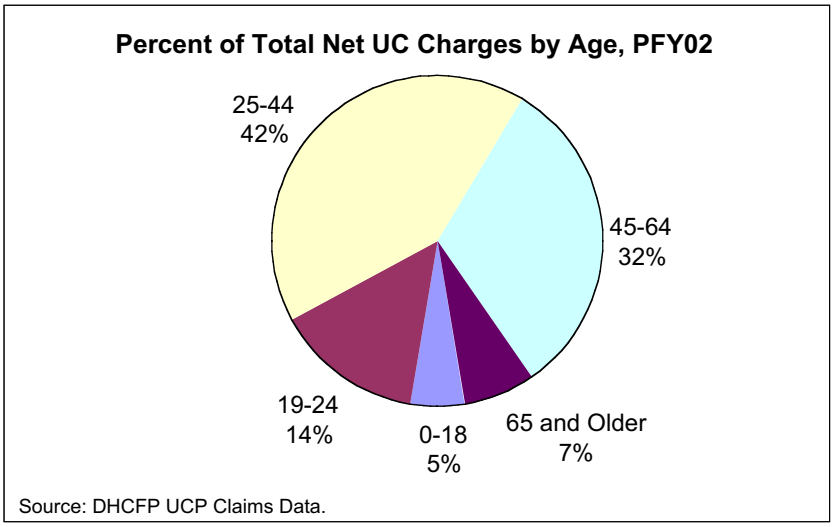


Figure 3. The greatest share of uncompensated care charges are incurred by young adults, age 25 to 44. 86% of charges are incurred by the entire non-elderly adult population, age 19 to 64.

[6] For additional information on pool data sources, please refer to Appendix A.

[7] Uncompensated care (UC) charges refer to net uncompensated care charges, including both free care and emergency bad debt. "Net" UC charges refers to charges net of recoveries made by providers; e.g., from automobile insurers.

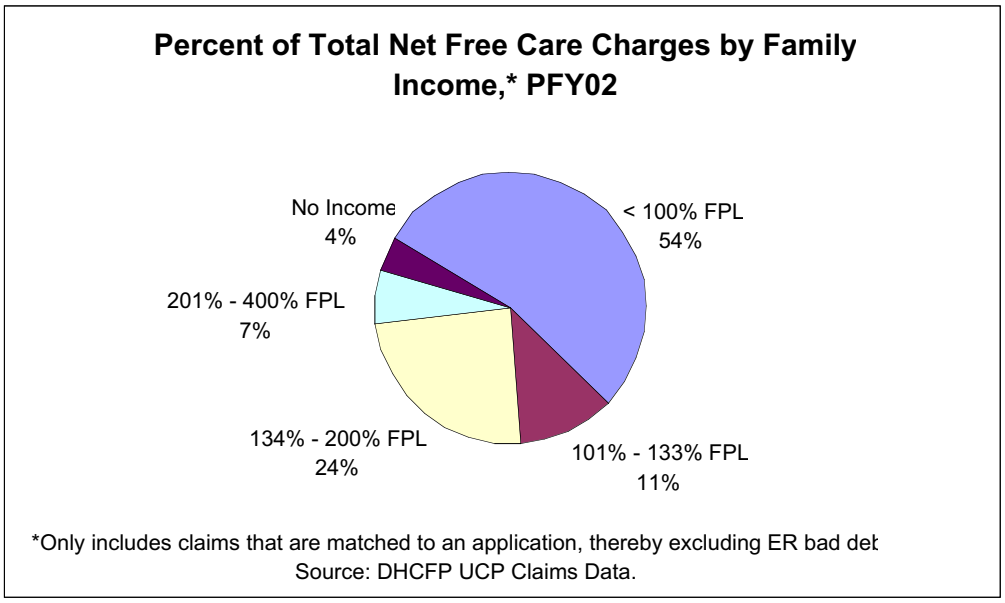


Figure 4. The majority of free care dollars are spent on individuals with family income at or below the federal poverty guidelines (FPL). Individuals with family incomes 201-400% FPL are disproportionately represented in the matched claims database (see Appendix A for description of this database0). Partial free care provided to individuals with family income of 201-400% FPL constitutes only 1.5% of the total free care charges for which hospitals ask the Pool to pay; e.g. "write off to Pool".

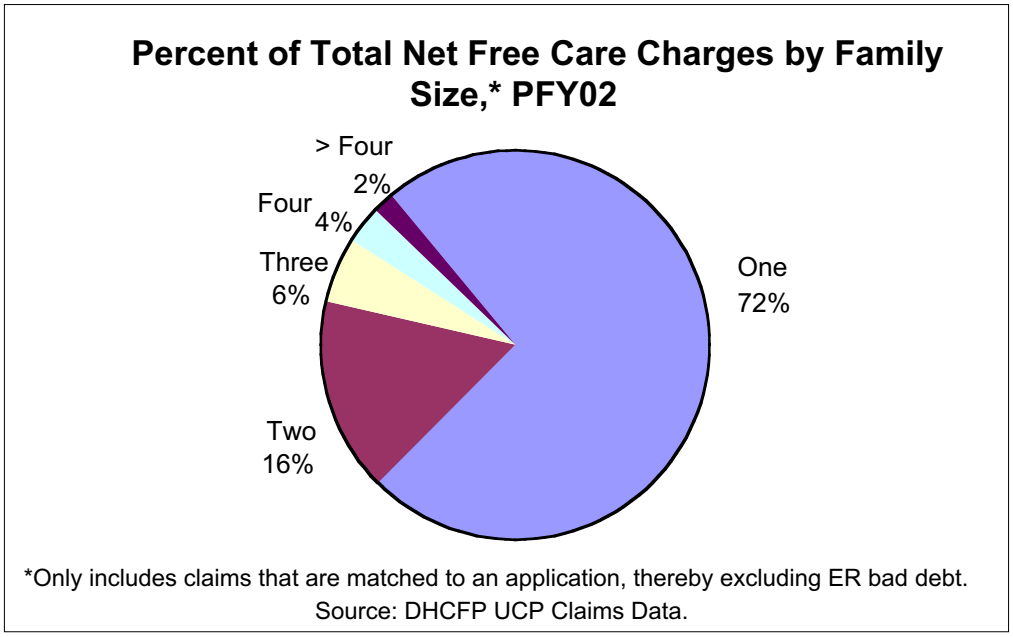


Figure 5. 72% of net free care charges are generated by individuals without families and an additional 16% are generated by 2-person families, comprised of two adults or an adult and child. Combined, one and two person families generate 88% of net free care charges.

4) Types of services paid for out of said pool funds in FY02

Claim Count & Net UC Charges by Type of Claim, PFY02				
	Claim Count	Percent	Total Net UC Charges (excludes CHCs)	Percent
Total Claims	**1,212,299**	**100%**	**$649,234,198**	**100%**
Total Inpatient Claims	*26,716*	*2%*	*$255,168,571*	*39%*
Total Outpatient Claims	*1,024,125*	*85%*	*$394,065,627*	*61%*
Total CHC Claims	*161,458*	*13%*	*na*	*na*
Total ERBD Claims	*151,684*	*14%*	*$118,117,704*	*18%*
Total Regular FC Claims	*897,929*	*86%*	*$532,017,436*	*82%*
Total Outpatient Claims	**1,024,125**	**100%**	**$394,065,627**	**100%**
Outpatient Pharmacy Only	*102,491*	*10%*	*$18,943,228*	*5%*
All Other Outpatient[8]	*921,634*	*90%*	*$375,122,399*	*95%*

Figure 6. This chart summarizes the PFY02 patient-level clinical services data currently available in the DHCFP database. This data, submitted to DHCFP in a UB92 claim format, represents 79% of all uncompensated care charges billed to the Pool.

The majority of uncompensated care claim records are for outpatient services, representing a greater proportion of the total uncompensated care charges. 13% of all claim records are generated by CHCs. Emergency bad debt (ERBD) represents 14% of all uncompensated care claim records and 18% of total uncompensated care charges.

Pharmacy charges represent 5% of all outpatient charges and 10% of all outpatient claim records.

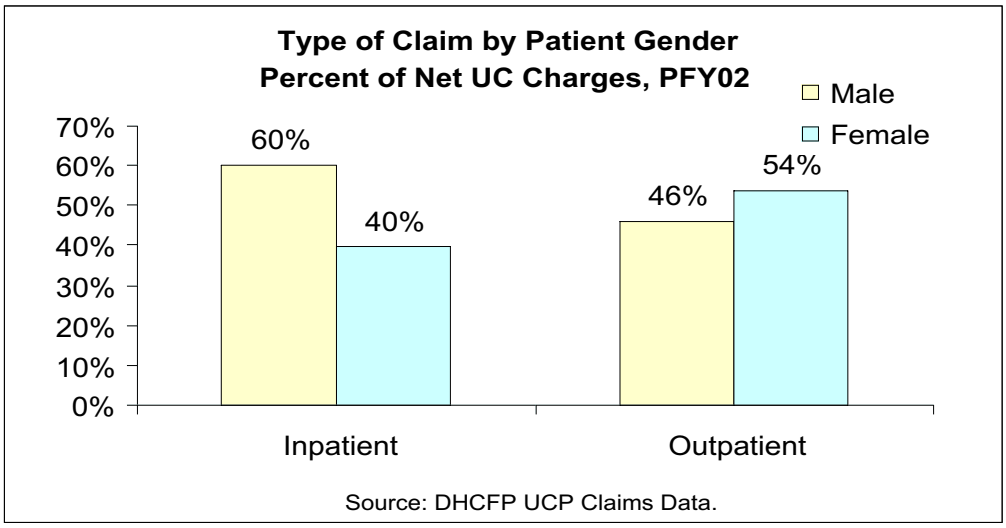


Figure 7. Males comprise a significantly larger proportion of inpatient charges, while females represent slightly more of the outpatient charges.

[8] Other outpatient charges includes charges for pharmacy when in combination with other services charged.

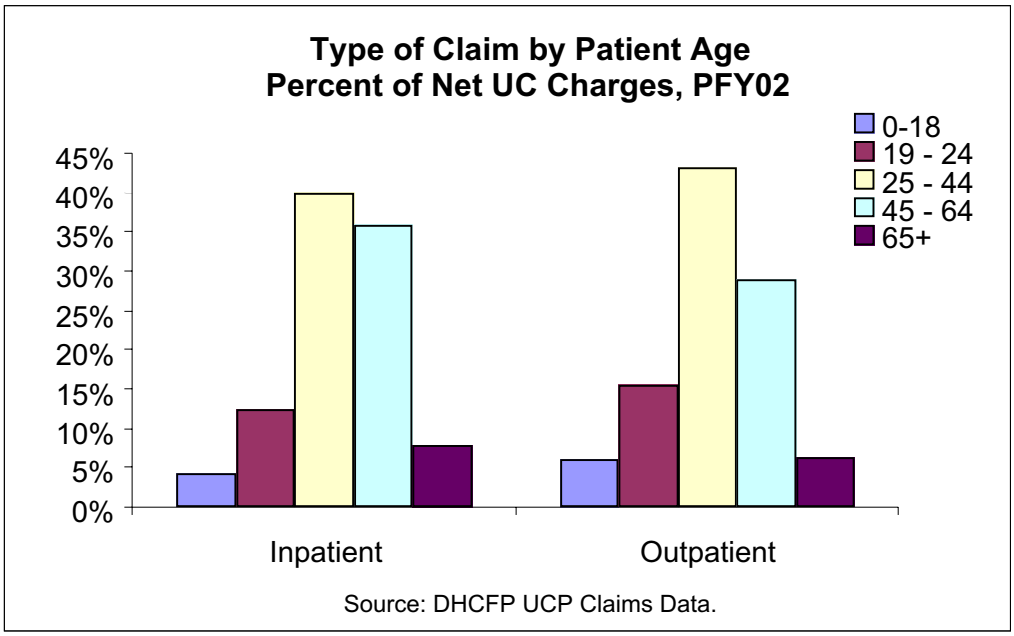


Figure 8. Pool users, age 25 to 64, represent the majority of both inpatient and outpatient uncompensated care charges.

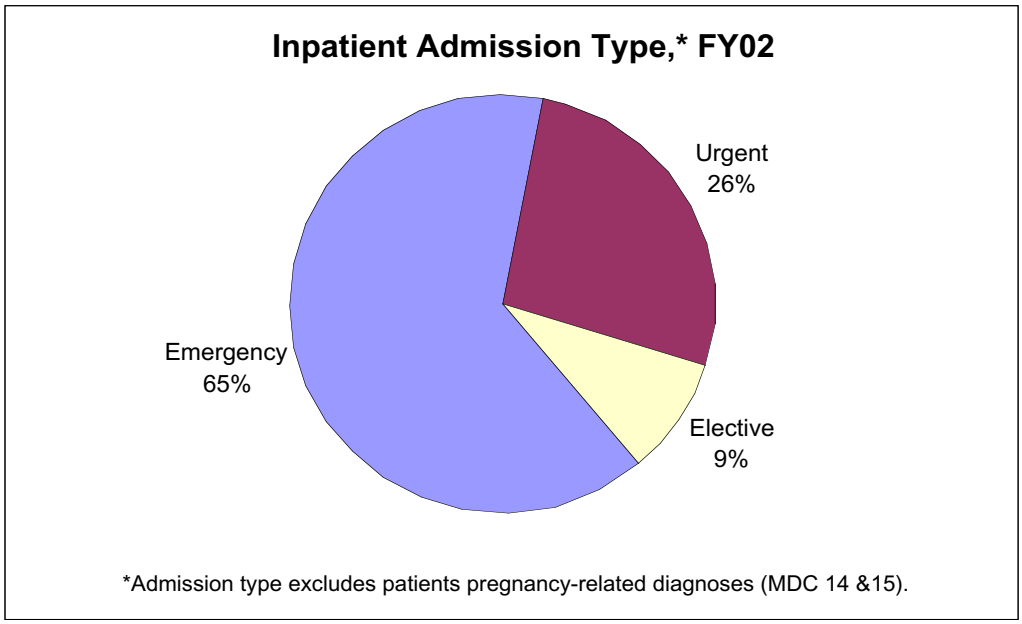


Figure 9. A greater share of free care inpatients are admitted as emergencies, while a smaller share are admitted for elective procedures.
Note: "Elective" indicates that the service was scheduled ahead of time; it does not indicate that the service was not medically necessary. For example, most surgeries to remove cancerous tumors are scheduled, and thus characterized as elective procedures.

Inpatient Major Diagnostic Category[9] for Free Care Patients, FY 2002 *Percent of Total Charges*		
UCP Rank	**MDC**	**Percent**
1	Circulatory System	18.9%
2	Digestive System	10.4%
3	Alcohol/Drug Use Related Mental Disorders	8.8%
4	Mental Diseases & Disorders	8.7%
5	Musculoskeletal System & Conn Tissue	7.3%
6	Respiratory System	7.1%
7	Nervous System	6.9%
8	Hepatobiliary System & Pancreas	5.6%
9	Skin, subcutaneous tissue & breast	2.8%
9	Female Reproductive System	2.8%
	Total	**79.2%**

Figure 10. Discharges for circulatory and digestive system diagnoses represents the largest shares of inpatient charges for free care patients. Mental health and alcohol/drug use related disorders represent a much greater share of inpatient free care charges than they do of other payers, including Medicaid.

Inpatient Characteristics of the Free Care Population, FY01-FY02		
	FY01	**FY02**
Casemix Index	1.37	1.49
Average Length of Stay	4.78 days	4.44 days

Figure 11.

The casemix index represents the amount of resources required to treat a given population. It is implied that the level of resources a patient requires is an approximation of their acuity level (i.e., level of illness). A casemix index of 1.00 suggests a given patient uses an average amount of resources, while a casemix of 2.00 implies a patient requires double the amount of resources.

According to this table, free care patients use slightly more resources, on average, in FY02 than in FY01.

The average length of stay for free care patients decreased slightly from FY01 to FY02.

[9] Inpatient diagnoses are classified into one of twenty-five major diagnostic categories (MDC). Discharges are grouped into MDCs using 3M's All Patient DRG Grouper, version 12.

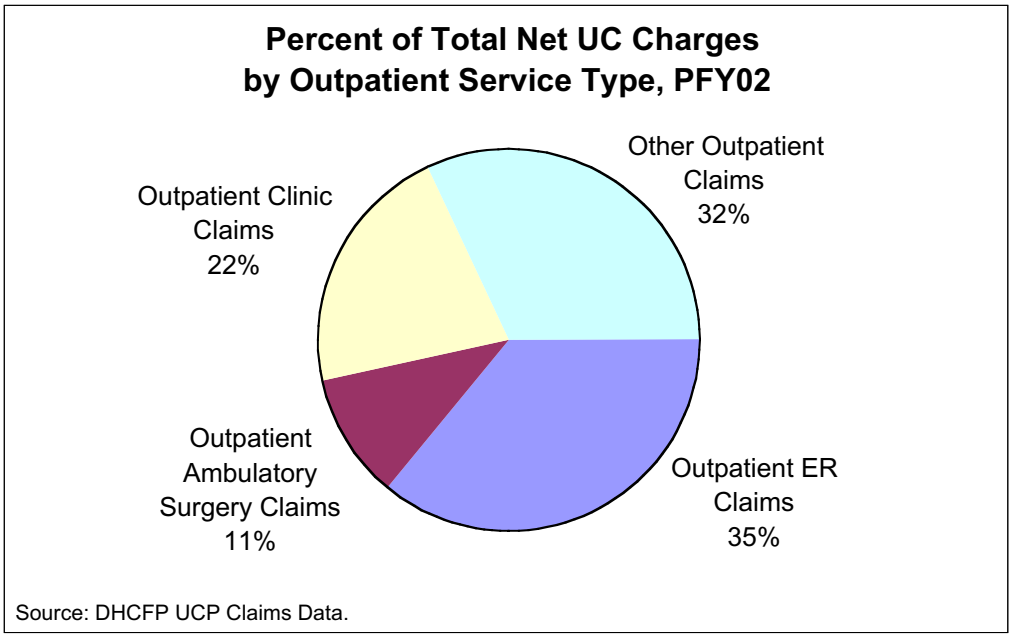


Figure 12. The largest proportion of outpatient uncompensated care charges are for ER services. Another 22% of outpatient uncompensated care charges are for clinic services.

Note that "other outpatient claims" include charges for ancillary services that may have been provided in conjunction with an emergency, ambulatory surgery, or clinic visits, but were billed separately.

5) Hospital Responsiveness to Enrolling Patients in MassHealth.

DHCFP regulations require the following at 114.6 CMR 10.04 (2):

> "Screening for alternative programs. Hospitals and Community Health Centers must screen patients for other sources of coverage and potential for eligibility in government programs before approving them for Free Care. Hospitals and Community Health Centers are required to document the results of each screening. If an Acute Hospital or Community Health Center determines that a patient is potentially eligible for Medicaid or another government program, said Acute Hospital or Community Health Center shall encourage the patient to apply for such program and shall assist the patient in applying for benefits under such program. A patient who declines to apply for another government program may apply and, if eligible, be approved for Free Care."

The Division's audits have found that hospitals and community health centers are generally in compliance with the Division's MassHealth screening requirements, and that they do assist patients with the MassHealth application process. However, the Division's regulations currently allow patients to decline to apply for MassHealth; therefore, not all patients who are eligible for MassHealth actually choose to enroll. The Division has found that MassHealth documentation requirements and immigration concerns are the most commonly cited reasons for declining to apply to MassHealth.

Note that the retroactivity period for MassHealth Standard is only 10 days before the date of application, and MassHealth will not pay for patients enrolling in MassHealth Basic until they are determined eligible and enrolled in a Managed Care Organization (MCO). Therefore, even if patients apply for MassHealth Basic on their date of service, charges for that date of service will be paid for by the Uncompensated Care Pool.

In addition, two-thirds of charges billed to the pool are billed more than one month after date of services. (See Figure 13) Most hospitals write off an account within one to two weeks of assigning liability to the Pool; the fact that most accounts are written off much later implies that the patients applied for free care well beyond the retroactivity period even for MassHealth Standard.

The PFY02 pool data indicates that about 30% of pool users are potentially eligible for MassHealth under current eligibility rules. (See Figure 14) Of those potentially eligible, 75% appear eligible for MassHealth Basic, which is being significantly cut as of April 1, 2003, and another 13% look eligible for MassHealth Standard. (See Figure 15)

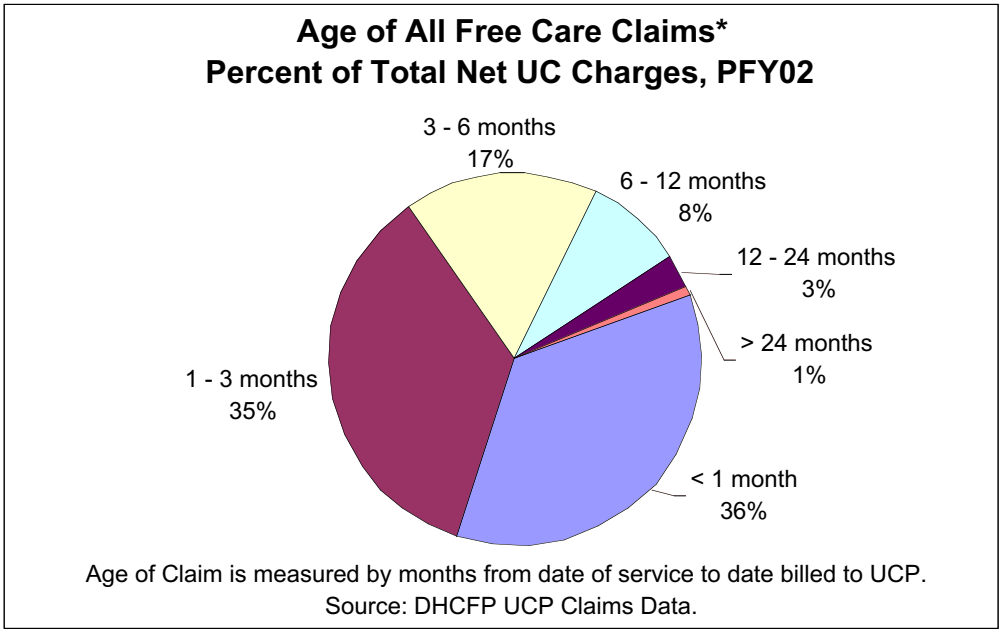


Figure 13 “Age of claim” is the amount of time between the date of service and the date the account was written off (billed) to the Pool. Because most hospitals write off an account within 1-2 weeks of assigning the liability to the Pool, "age of claim” can be used as a rough approximation of the amount of time between the service date and the free care determination. Patients who applied for free care prior to this date of service would be included in "<1 month".

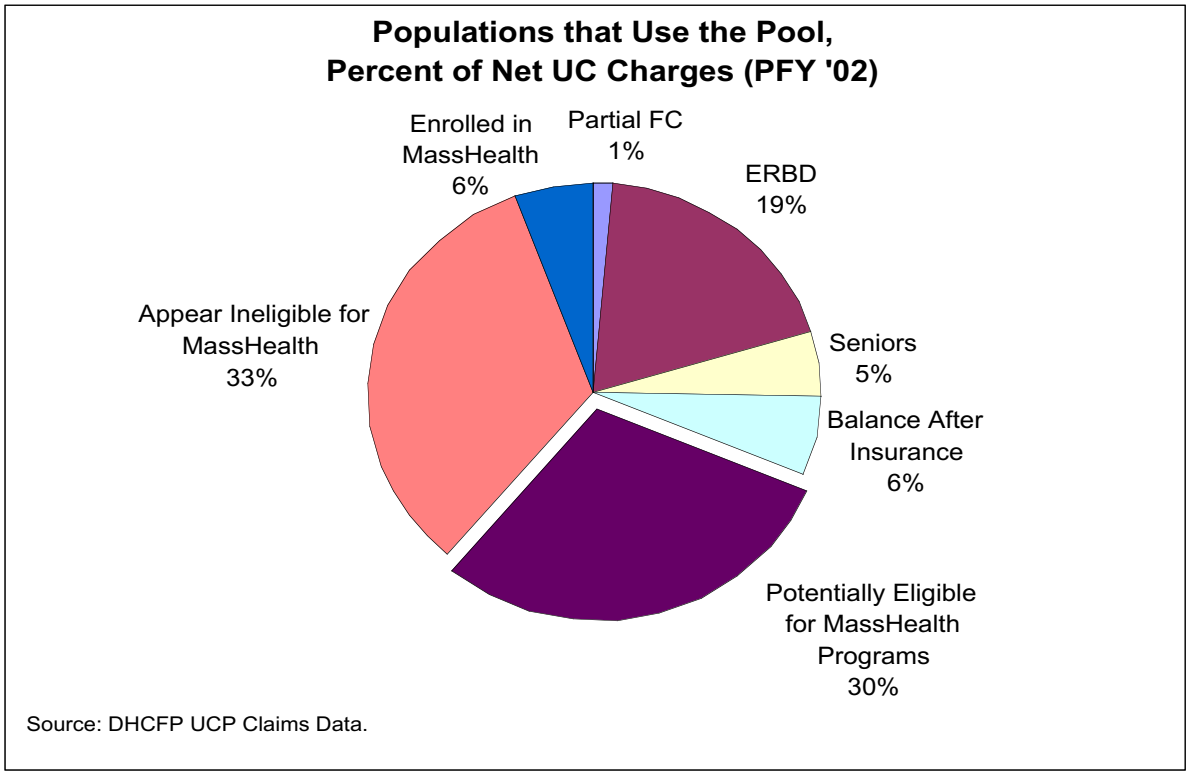


Figure 14. The Pool pays for patient care under many different circumstances. Providers are required to try to screen all free care applicants for eligibility for other programs. The largest group of Pool users are low-income, uninsured individuals who are ineligible for MassHealth; however, this group represents only 33% of charges to the Uncompensated Care Pool. The Pool also pays for low-income individuals for:

- services not covered by other programs (e.g. MassHealth Limited and Children's Medical Security Plan);
- services provided prior to MassHealth eligibility dates;
- services provided to patients who apply too late for MassHealth to cover this service date, even though they might have been eligible before the date of service;
- patients who decline to apply for MassHealth or other programs which might otherwise have been responsible to pay for the services;
- balances after insurance for private patients;
- balances after insurance for Medicare patients,
- seniors ineligible for Medicare;
- bad debt resulting from emergency services provided to uninsured patients (patients for whom no application form was completed); and
- partial free care for individuals with incomes 200-400% FPL.

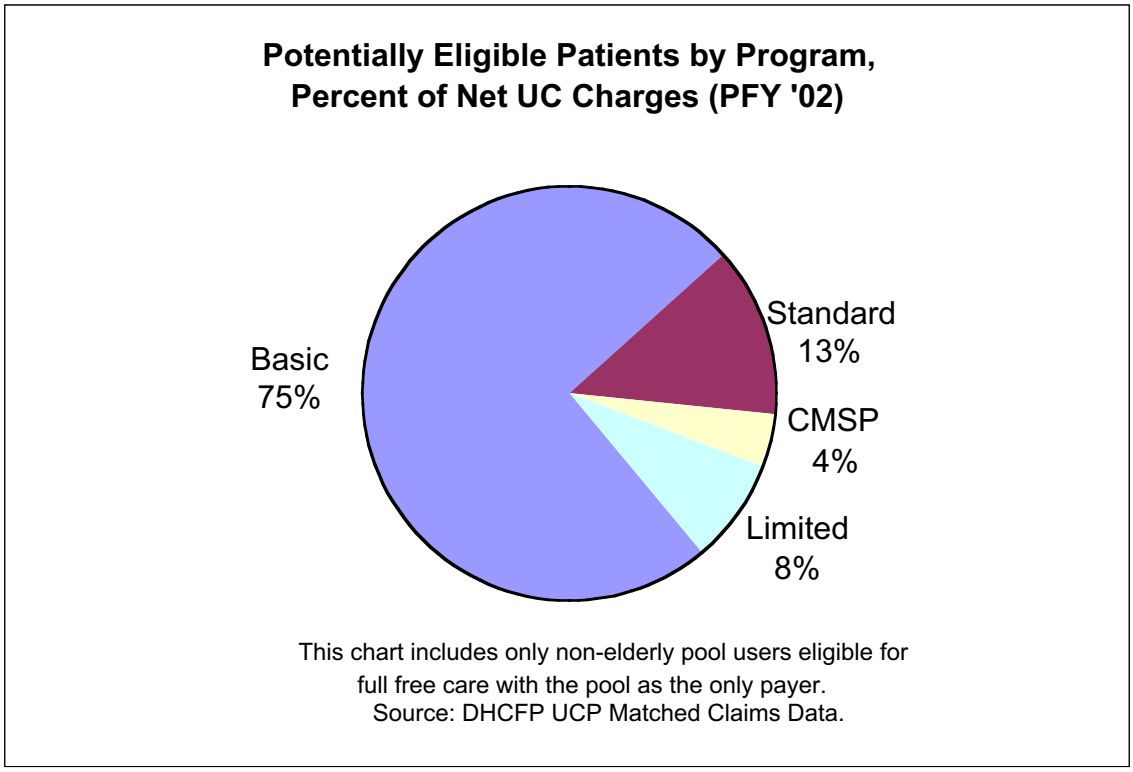


Figure 15. The free care application includes questions that are designed to determine whether an applicant could potentially be eligible for MassHealth or other programs. Providers are required to assist those patients who are potentially eligible to apply for the relevant program. Note that the Uncompensated Care Pool database does not include sufficient information to make an official determination of MassHealth eligibility, but, the screening information it does contain allows one to separate those who are clearly ineligible for MassHealth and other programs from those who could potentially be eligible..

Of Pool users who could potentially be eligible for one of the MassHealth benefit plans or the Children's Medical Security Plan (CMSP), about 75% are potentially eligible for MassHealth Basic under current eligibility rules. Another 13% are potentially eligible for MassHealth Standard.

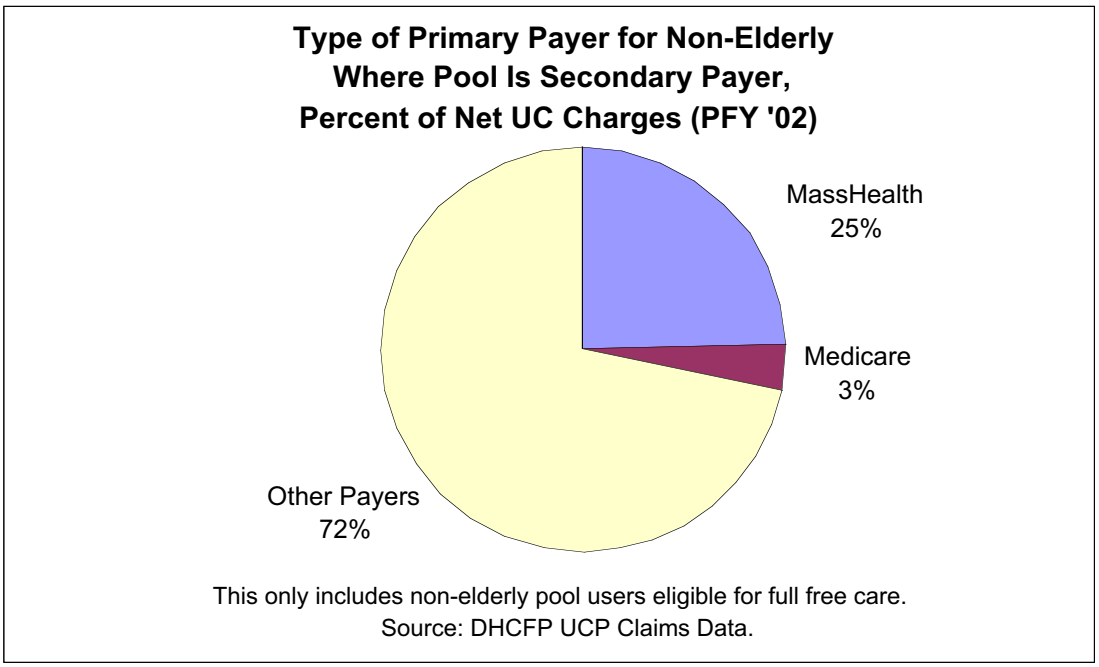


Figure 16. Only a minority of non-elderly patients who use the Pool as a secondary payer have either Medicaid or Medicare.

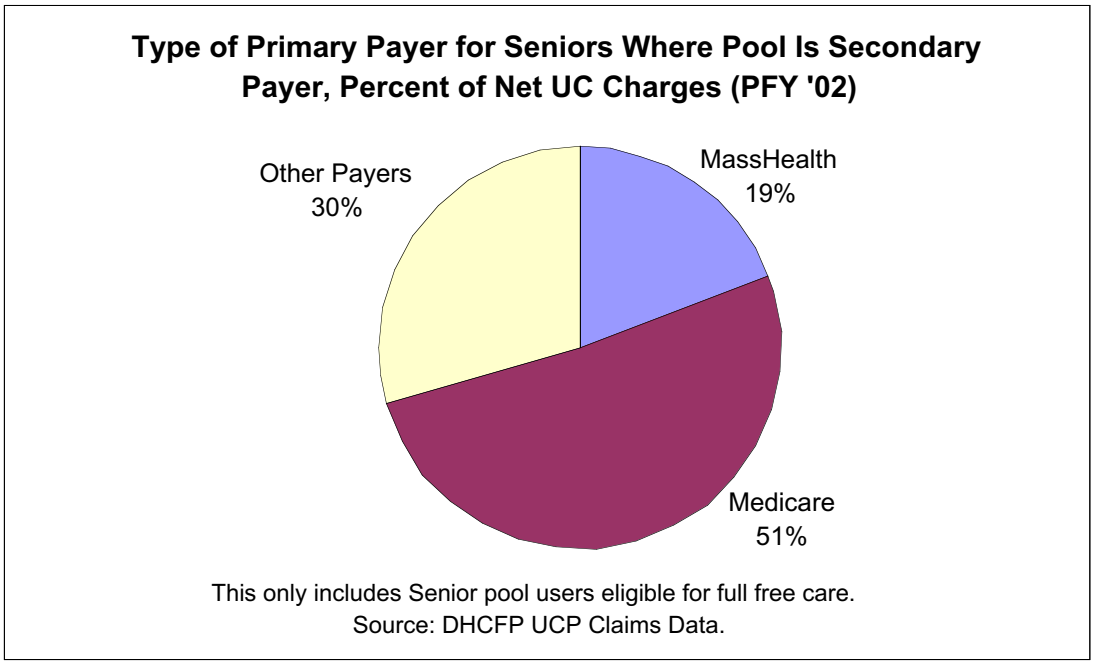


Figure 17. Medicare is the primary payer source for the majority of Seniors who use the Pool as a secondary payer. Other payers includes private indemnity insurance, Medicare supplemental, Tricare and the like.

6) Recommendation for Encouraging Hospitals to Enroll Potentially Eligible Individuals into MassHealth Before Charging the Pool.

As noted in section 5, hospitals are already required to encourage patients to enroll in MassHealth. As an additional incentive, MassHealth pays for a wider range of services than the Pool, which benefits patients and affiliated physicians, and may directly benefit the hospital itself.

However, there may be insufficient incentives for patients to apply for MassHealth, particularly if they incurred bills at some point in the past, but are currently healthy. Federal law prohibits requiring patients to apply for Medicaid. Therefore, the DHCFP recommends not allowing patients to apply for free care if, based on screening criteria, they appear to be MassHealth eligible, unless they have already completed a MassHealth application.

Appendix A: Data Notes

Data used in this analysis was drawn from the following sources:

1. UCP Claims database: Hospitals and CHCs began electronic submission of data elements from UB-92 claims forms to DHCFP in March, 2001. As with applications, most providers are complying with this requirement, however most have not submitted 100% of the required claims data electronically. The database contains data from 2 million claims forms, documenting over $1 billion in uncompensated care charges, as of September, 2002. Claims data written off to free care ("billed" to the Uncompensated Care Pool") in FY02 (October, 2001 through September, 2002) were used for this analysis.

2. UCP Applications database: Hospitals and CHCs began submitting electronic free care applications forms to the Division of Health Care Finance and Policy (DHCFP) in October, 2000. Most providers are complying with this requirement, however most have not submitted 100% of their free care applications electronically. The database contains data from 385,000 application forms, as of November 2002. Note that this data is as reported by the applicant, with documentation for income and residency.

3. Merged UCP Applications and Claims database: To the extent possible, DHCFP has matched claims data to applications data. Matching was based on social security number or tax identification number where available. Additional matches were based on other available data such as phonetic last name, phonetic first name, date of birth, provider, etc. There is no application associated with Emergency Bad Debt (ERBD), so ERBD claims data is excluded from the match. Approximately 40% of claims data has been matched to applications. Claims data written off to free care ("billed" to the Uncompensated Care Pool") in FY02 (October, 2001 through September, 2002) were used for this analysis.

Appendix B:

Uncompensated Care: Sources and Uses of Funds PFY98-03 (in millions)

Sources of Funds	PFY 98*	PFY 99*	PFY 00*	PFY 01**	PFY02**	PFY03**
Uncompensated Care Pool						
Hospital Assessment	215.0	215.0	215.0	215.0	170.0	170.(
Surcharge on Payments to Hospitals	100.0	100.0	100.0	100.0	100.0	100.(
State Appropriation	30.0	30.0	30.0	30.0	30.0	45.(
Total Uncompensated Care Pool	345.0	345.0	345.0	345.0	300.0	315.(
Other Funds						
Intergovernmental Transfer (IGT)	70.0	70.0	70.0	70.0	70.0	70.(
c.495 §56 Compliance Liability Funds	4.0	-	15.0	1.1	0.0	0.(
Prior Fiscal Year Surplus Transfer	-	-	9.0	2.0	0.0	0.(
Transfer from Medical Security Trust Fund	-	-	15.0	25.0	90.0	0.(
Transfer from Tobacco Settlement Trust	-	-	-	-	12.0	30.(
Total Uncompensated Care Funds Available	**419.0**	**415.0**	**454.0**	**443.1**	**472.0**	**415.(**
Uses of Funds						
Payments						
Hospital Free Care Costs	390.0	381.9	383.4	404.0	429.4	455.2
CHC Free Care Costs	16.5	14.5	15.9	17.6	22.5	23.9
Demonstration Projects	3.0	3.3	5.2	5.5	5.0	3.1
Transfer to Children's & Seniors' Health Care Assistance Fund***	-	11.8	46.3	44.3	33.8	11.25
Est. Impact of MassHealth Basic****	-	-	-	-	-	76.5
Audit Adjustments	-	-	(3.9)	(4.2)	(4.2)	(4.3
Reserves						
Doubtful Accounts - Hospitals	-	-	-	1.0	1.0	1.(
Doubtful Accounts - Surcharge Payers	-	-	-	0.3	0.3	0.3
Data Collection	-	3.0	2.0	2.8	1.5	1.5
Surcharge Expenses	-	-	-	-	-	
Other Reserves	0.5	-	-	-	-	
Total Uses of Funds	**410.0**	**414.5**	**448.9**	**471.3**	**488.9**	**567.5**
Shortfall) / Surplus	**9.0**	**0.6**	**5.1**	**(28.2)**	**(16.9)**	**(152.5**

* PFY 98, PFY 99, and PFY00 data is as of Preliminary Settlement.

** This is a projection. The final shortfall/surplus estimate can be higher or lower by up to 5%, depending upon the assumptions.

*** Assumes transfer to C&S reinstated in State Fiscal Year 04.

**** These cuts are effective 4/1/03. The PFY 2003 estimate is for six months (April - September 2003). Cost to Pool is based upon FY02 MassHealth Basic spending adjusted to reflect Pool benefits, utilization, and payment levels.

Source: Uncompensated Care Pool PFY02 Interim Report, Table 7; September, 2002.

Appendix C: Challenges in Projecting Free Care Costs

The Division projects free care costs and Pool shortfalls or surpluses on a regular basis. Projecting free care costs is extremely difficult because of the large number of factors that can affect final amounts. We discuss these factors below.

First, the Pool is the payer of last resort. The Pool pays for any medically necessary service provided by an acute hospital or community health center to a low-income uninsured or underinsured person that is not covered by another payer. Therefore, if there are any changes in enrollment or services covered by any other public or private payer, the changes will affect the Pool. Changes in other programs, such as MassHealth, often are not announced publicly until after they have taken effect, and even then, it is very difficult to quantify the direct impact that the change will have on the Pool.

Second, because most private insurance is accessed through employment, changes in employment levels, types of employees hired (full-time vs. contracted or part-time), and/or the level of benefits offered will affect the Pool.

Third, the Pool is required by law to pay providers on a fee-for-service basis. If the amount a provider bills to the Pool increases by 50% in a particular month, the Pool must reimburse the hospital for the increased amount. A provider may bill higher amounts for many reasons: expanded services, increased volume, an epidemic, installation of a new billing system, and so on.

Finally, the Pool is not a program, and it does not enroll members. The Division cannot project costs based on enrollment per member per month (PMPM) multiplied by cost per member per month as health plans do. Because people often apply for free care after they have received a service, the Pool has not implemented pre-admission certifications and other methods of utilization review. As a result, the Division does not get advance warning of high-cost procedures being billed to the Pool.

Source: Uncompensated Care Pool PFY01 Annual Report, Section 6; August, 2002.